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Testimony of Mass Home Care
Submitted to the
Massachusetts Public Health Council
and the Massachusetts Attorney General
July 29, 2010

Re: The Caritas Christi Hospitals

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Public Health Council
99 Chauncy Street, 2nd Floor
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Public Charities Division/Caritas Transaction
Office of Attorney General Martha Coakley
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Mass Home Care is a network of 30 agencies, 29 of which are non-profit, and 1 which is a department of municipal government. Our statewide Association, which is 27 years old, seeks to help elderly and disabled individuals to live in the least restrictive setting possible, at their highest level of functioning possible, for as long as possible.

Our member agencies are all affected by the proposal of Cerberus Capital Management to purchase the six Caritas Christi Hospitals. We have member agencies in every city and town serviced by these community-based hospitals, and hundreds of elderly clients who use these hospitals. Historically, these facilities have developed a number of vital services and connections with the elderly community, which need to be maintained and expanded to deal with the growing elderly demographic in their areas.

It is our hope that the acquisition of these hospitals will not only support such community-focused services, but provide the opportunity to enhance these facilities' role in the community. Toward that end, we urge that Cerberus be required to present a detailed Community Benefits Plan that deepens its hospitals' commitment to serving the elderly and disabled populations in its service area. This acquisition should be used to increase the commitment of these hospitals to address the health and social needs in the communities they serve, and to formulate programming that targets the particular needs of under-served and at-risk populations, such as the elderly and disabled. The Community Benefits Plan also gives these facilities the context for reporting on community benefit initiatives and expenditures.

Such a Community Benefits Plan generally should include the following essential services:

1. Each hospital should create a Geriatric Support Services Coordinator who is responsible for coordinating hospital services for the elderly with community-based groups that serve seniors, such as the Area Agencies on Aging, and the Aging Services Access Points.

2. Each hospital should develop a Geriatric Support Services Plan with a three year timeline, that specifies the services and outreach the hospital plans to make with the communities it serves, based on periodic community needs assessments. This workplan should set specific service goals annually, and be developed in consultation with community-based groups working with the elderly and disabled.
3. Each hospital should maintain an active and expanding involvement with its elderly community, engaging in projects that will ensure that elderly consumers encounter a seamless and coordinated system of supports as they change care settings. Such services include:

a. care transitions coaching, a post-discharge service that follows the consumer as they return to their homes with a medical plan of care and support services needs, and that teaches them how to recognize 'red flags' in their own health conditions, and reduce hospital readmissions.
b. medical homes coordination: working with primary care practices and community groups to ensure that the hospitals' services are part of an integrated plan of care for the consumer
c. chronic condition self-management programs that teach consumers how to improve their own health, and how to become a more active player in their own health needs.
d. care coordination services, ensuring that the on-going medical needs of the elderly and disabled are integrated with their functional and long term care support needs.
e. healthy aging programming: including such evidence based programs as A Matter of Balance, Diabetes Self-Management, Depression Management, Enhanced Wellness, Powerful Tools for Caregivers, etc.
f. geriatric mental health outpatient services: working with local behavioral health providers and ASAPs to create the capacity to conduct in-home behavioral health services for at-risk populations.
g. provide free and accessible shuttle services between the hospital campuses for the disabled, elderly and underserved; agreed to investigate whether additional services are needed once the needs assessment is completed.

4. Each hospital should earmark funds to provide the resources needed to support implementation of its annual Community Benefits Plan, including grants to community groups to develop and maintain the services listed above, and other local services identified in community based needs assessments.

At the local level, some of our members have specific projects that they want to see continued and expanded. We want to ensure that each hospital maintains an active and expanded involvement with its elderly community. Here are 5 hospital-specific comments submitted by our members:

- **Holy Family Hospital:** This is one of the hospitals working with Elder Services of Merrimack Valley on a Transition Coaching service, and on chronic disease self-management. Holy Family has been very responsive in the past to requests from community based agencies for support and

involvement in elderly services. Our members hope that the acquisition by Cerberus will allow the facility to increase its investment in such services. Mass Home Care would like to see Holy Family engaging not only in such services as transportation for the elderly to hospital-based services, but investing in the volunteer Medical Advocacy program, as well as such programs such as Money Management, nutrition, and guardianship.

- **St. Elizabeth's Hospital:** Mass Home Care members would like this hospital to support transportation services for consumers needing hospital based services, including to their affiliated medical buildings, as well as funding or in-kind support for healthy aging programs. We would like see St. Elizabeth's engage with area ASAPs on medical homes and hospital discharge/care transitions programming.
- **Norwood Hospital:** Mass Home Care would like to see expansion of community based programs like the elder dental health program at Norwood, operated under the Community Visiting Nurse Association, to continue to provide low-income seniors with dental care; a transportation program assisting elders with rides to and from the hospital's satellite treatment centers, e.g. a shuttle service from Norwood Hospital to its oncology treatment center in Foxboro; an increase in the capacity of the gerontology psychiatry unit; increased investment in substance abuse programs to allow for appropriate detoxification and rehabilitation of older consumers with substance abuse issues; partnering with the local ASAP to create a care transitions model to improve post-discharge supports for seniors; enhance the existing Project Care program to ensure that community discharges are comprehensive and successful.
- **Saint Anne's Hospital:** Mass Home Care members would like to see an expansion of the elderly dental program from Norwood into the Saint Anne's area. We would also urge creation of transportation services for seniors needing on-going hospital services, such as dialysis or chemo/radiation services provided by Saint Anne's.
- **Good Samaritan:** This hospital has had a strong commitment to working with the surrounding communities. They formed a Values and Community Benefits Committee which worked on helping needy families and individuals in the community (particularly children and elders). The staff at Good Sam have done several fund raising events. The monies raised have been used for mini grants - grants were given to organizations who could help needy children and elderly with such things as food, shelter, medications, etc. OCES received a mini grant from them two years in a row to help purchase medication to low income seniors. Every month Good Sam holds a free luncheon for Seniors. Most of the time there is an educational component to these, i.e., info on Heart Disease, Diabetes, etc. One of their strongest areas has been their Interpreter Services. They have helped many elderly individuals who speak no, or very little, English with understanding their medical issues - explaining what their particular medical condition is; what

the doctor will be doing; what they will have to do or what meds they should take as a result, etc. They also help with the Medicaid process, explain and assist with completing the Medicaid application and inform them of other available services/benefit programs. They also have an excellent Geri Psych unit – something needed and we would want to see continue. In addition to the programs listed above, which we'd like to see continued, our members would like to see their relationship with Good Sam expanded to include chronic disease self management; hospital discharge/care transitions and medical homes initiatives.

Finally, Mass Home Care echoes the concerns raised by other groups that the Cerberus agreement:

1) be extended beyond the three year timeline
2) that the financial viability of this takeover be carefully assessed.
3) that the community be given at least six months prior notice, and the ability to be part of a public hearing process, for any plans by Cerberus to close a facility, or substantially alter its services to the public.
4) that a first position preference be given to any non-profit entity willing to assume control of any facility or service that Cerberus does not wish to maintain as part of its holdings.
5) that any services provided be culturally competent, with appropriate bi-lingual staff, and that the quality of interpreter services be monitored through patient satisfaction surveys.
6) that the hospitals provide an annual report on compliance with its commitments through the Community Benefits Plan, stating the amount of community benefits providing, and allowing the public to comment on the CBP report.

Mass Home Care appreciates the opportunity to submit this testimony on the Caritas Christ hospital network. For further information contact:

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